STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365588	A. Building B. Wing	09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arcadia Valley Skilled Nursing and Rehabilitation	25675 East Main Street Coolville, OH 45723

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28923 THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NON-COMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY. Based on closed record review, review of the facility's timeline and related investigation, review of an emergency medical services (EMS) run report, staff interview, review of employee files, and policy review, the facility failed to provide basic life support, including CPR, to Resident #44 as per the resident's advance directives, when the resident was found unresponsive and without a pulse/ heartbeat. This resulted in Immediate Jeopardy and serious life-threatening harm, negative health outcomes, and subsequent death on [DATE] at 10:30 P.M. when Resident #44 did not receive CPR, due to the facility staff inaccurately identifying the resident's code status as being a Do Not Resuscitate Comfort Care Arrest (DNRCC-A) from a report sheet, instead of a full code that was identified in her medical record and what she elected, as part of her advanced directives upon admission to the facility. CPR was not initiated, and Emergency Medical Services (EMS) were not called until approximately an hour and fifteen minutes after the resident was found unresponsive and without a pulse. Resident #44 was subsequently transported to the hospital and was pronounced deceased upon her arrival. This affected one resident (#44) of three residents reviewed for death in the facility. The facility census was 43 residents. On [DATE] at 8:57 A.M., the Administrator, Director of Nursing (DON), Regional Director of Operations (RDO) #225, and Director of Quality Assurance #250 were notified Immediate Jeopardy began on [DATE] at approximately 10:30 P.M. when Resident #44 was found in her bed unresponsive and without an obtainable pulse. Nursing staff on duty did not correctly identify the resident's code status as they used information documented on an internal staff report sheet that inaccurately identified the resident as a DNRCC-A, when the resident elected to be a full code upon her admission. The resident's actual code status as a full code was not determined until later that night, when a facility nurse was reviewing the resident's electronic medical record for next of kin information and funeral home preference. The facility nurse then contacted the DON who directed staff to initiate CPR and to call 911. CPR was initiated one hour and 15 minutes after the resident was initially found unresponsive and without any obtainable pulses. The resident was transported to the hospital where she was pronounced deceased upon her arrival. The Immediate Jeopardy was removed and corrected on [DATE] when the facility implemented the following corrective actions: (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 11:45 P.M., Licensed Practical Nurse (LPN) #150 was reviewing Resident #44's electronic medical record to obtain next of kin information and funeral home preference when she discovered Resident #44's code status was a full code. The DON was notified, and a directive was given to initiate CPR and to call 911. CPR was initiated and EMS were called. On [DATE] at 12:11 A.M , Resident #44 was transported out of facility via EMS. On [DATE] at 2:00 A.M., one Registered Nurse (RN), two LPNs, two State tested Nursing Assistants (STNAs) on site were re-educated by the DON on timely delivery of services and care, change of condition, and notification, and where to find code status orders (in Point Click Care (PCC)). RN #100 (the staff member identified to be responsible for the error in not initiating CPR timely) was suspended pending investigation. On [DATE] 9:01 A.M., All staff re-education was initiated related to change in condition, timely delivery of care and services, documentation, where to find code status orders (in PCC), and notification by the DON, ADON, and Regional Quality Assurance Registered Nurse via in person or telephone. Staff trained included five RNs, nine LPNs, 19 STNAs, three housekeeping staff, three dietary staff, and one activity personnel. On [DATE] at 10:00 A.M., the Social Service Designee attempted to contact Resident #44's family without success. A voicemail was left. The Social Services Designee and preceptor began an audit of all 43 resident's advance directives' orders and advance directives on file in chart. Each was verified and cross-referenced for accuracy. Any identified findings were corrected upon discovery. On [DATE] at 10:10 A.M., the Human Resource Director verified CPR certification of RN #100 and LPN #150 and began audits of all licensed nurses (five RNs and nine LPNs) CPR certifications. Any identified findings were addressed immediately. On [DATE] at 10:30 A.M., All current report sheets were removed from the facility and replaced with new report sheets that did not include the resident's code status by Regional Director of Quality Assurance RN. On [DATE] at 11:37 A.M., the facility Medical Director was notified by the DON of the incident involving Resident #44 and the delay in CPR initiation and current process of correction. On [DATE] at 12:52 P.M., All staff on shift interviews were completed with RN #100, LPN #150, STNA #175, and STNA #200, who were all of the staff on duty on [DATE] when Resident #44 was found unresponsive and without an obtainable pulse. Re-education was provided related to change in condition, timely delivery of care and services, documentation, where to find code status orders (in PCC), and notification by the Regional Director of Quality Assurance RN. On [DATE] at 4:00 P.M., All licensed nurses not CPR certified (two RNs and three LPNs) were removed from direct patient care by the Administrator and not utilized in the role as a licensed nurse until their CPR certification was current. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 5:15 P.M., All staff re-education (which included five RNs, nine LPNs, 19 STNAs, three housekeeping staff, three dietary staff, and one activity personnel) was completed by the DON, ADON, and Regional QA nurse related to change in condition, timely delivery of care and services, documentation, where to find code status orders (in PCC), and notification. On [DATE] at 6:56 P.M., the advance directives/code status for all 43 facility residents was verified and cross referenced, orders in PCC verified, and audit completed by Social Services Designee. On [DATE] at 9:00 A.M., a crash cart (cart with emergency supplies/equipment) audit was completed by the DON to ensure all required supplies were present on the cart and the cart was replenished. On [DATE] 11:00 A.M., all licensed nurses (five RNs and nine LPNs) CPR certifications were current and valid. An Ad hoc Quality Assurance (QA) meeting was held. The facility implemented a plan for all licensed nursing staff CPR certifications to be verified upon hire, annually, and evaluated during annual performance evaluations. Interviews with RN #300 on [DATE] at 8:08 A.M., RN #300 on [DATE] at 8:12 A.M., and STNA #370 on [DATE] at 12:30 P.M., confirmed they received re-education following the incident involving Resident #44 on [DATE]. Re-education was provided by [DATE] and included what to do when finding a resident unresponsive and without an obtainable pulse, timely CPR, where to find code status orders (in PCC), and physician/ family notification. Findings include: Review of Resident #44's closed record revealed the resident was admitted to the facility on [DATE] with the diagnoses of sepsis, urinary tract infection, pressure ulcer of the sacrum, chronic obstructive pulmonary disease (COPD), acute congestive heart failure (CHF), adult-onset diabetes mellitus, atrial fibrillation with flutter, hypertension, history of pulmonary embolism, and malignant neoplasm of the endometrium. Review of Resident #44's physician's orders revealed the resident was a full code (advance directives). The order originated on [DATE] (date of admission). Record review revealed a plan of care, initiated on [DATE] indicating the resident's advance directives included she was a full code per the resident's wishes. The goals were for the resident to be kept safe and comfortable, receive artificial resuscitation, and for her to remain a full code. Interventions indicated advanced directives would be placed on the chart, call 911 for emergency help if needed, code status to be reviewed at least quarterly/ annually/ and as needed (prn) with resident/ family/ responsible party, staff would initiate CPR until EMS arrived, staff would notify physician of resident wishes and carry out orders, and staff would update family/ responsible party of resident wishes. Review of Resident #44's admission Minimum Data Set (MDS) assessment dated [DATE] revealed the resident did not have any communication issues and was able to make herself understood and was able to understand others. The assessment revealed the resident was cognitively intact and was not known to display any behaviors or reject care during the seven days of the assessment period. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident #44's nursing progress note dated [DATE] at 10:25 A.M. and authored by the DON revealed the resident was swabbed for COVID-19, as part of the facility's outbreak testing, and was found to be positive. The physician and the resident's family were notified. The resident was placed in droplet isolation precautions. Review of the census tab in Resident #44's electronic medical record (EMR) revealed (on [DATE]) after testing positive for COVID-19, the resident was moved from her current room to a different room. No additional room changes occurred after this date. A nursing progress note dated [DATE] at approximately 10:35 P.M. and authored by RN #100 revealed she was called to Resident #44's room by STNA #175. LPN #150 was already in the resident's room. Resident #44 was found unresponsive with no pulse able to be palpated at that time. A physical assessment was completed with no heartbeat able to be auscultated. No vital signs were noted to be present. Findings were verified by both nurses (RN #100 and LPN #150). The note indicated the resident was thought to be a DNRCC-A, and no further action was taken at that time. Review of a nursing progress note dated [DATE] at 12:00 A.M. and authored by RN #100 revealed at 11:50 P.M. Resident #44's code status was verified, CPR was initiated, and Emergency Medical Services (EMS) were called (approximately an hour and 15 minutes after the resident was found to be unresponsive and absent for any obtainable pulses or vital signs). The resident left the facility at approximately 12:11 A.M. via EMS enroute to the local hospital. Review of the EMS run report dated [DATE] with incident #5024007014 revealed the ambulance service responded to the facility for a cardiac arrest. The call was received at 11:45 P.M., they were enroute to the facility at 11:47 P.M., on site at 11:49 P.M., and providing services on the resident (Resident #44) at 11:51 P.M. The duration of the cardiac arrest was indicated to be 10 minutes. Resident #44 was found by EMS unresponsive upon their arrival. She was transported to the local emergency room (ER) arriving there at 12:23 A.M. Advanced life support was provided enroute to the hospital. The emergency departments reported complaint on the EMS run sheet was cardiac arrest/ death. The resident's condition at the destination (ER) was indicated to be unchanged. Review of the facility's timeline of Resident #44's unresponsiveness with no obtainable pulse and delayed CPR revealed the following: On [DATE] at 10:35 P.M., Resident #44 was found by an STNA, STNA #175 unresponsive. Two nurses (RN #100 and LPN #150) verified the absence of vital signs, respirations, and pulse on the resident. The resident's code status was verified at time via report sheet, and she was thought to be a DNRCC-A. Time of resident's death was called and verified by the two nurses. On [DATE] at 11:40 P.M., LPN #150, who was assisting RN #100 with contacting family/ funeral home etc., pulled Resident #44's face sheet (profile) from the facility's computer software program (point click care) looking for additional family contacts and funeral home election when she noticed the resident was a full code. She contacted the facility's DON, who instructed them (staff) to start CPR immediately and call 911. On [DATE] at 11:50 P.M., LPN #150 instructed STNA #200 to call 911 and she alerted nurse RN #100, and they initiated CPR. Both nurses provided CPR without cessation. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 12:11 A.M., EMS arrived at the facility and care of Resident #44 was transferred (to EMS). CPR remained in progress by EMS and the resident was transported to the emergency room (ER) by EMS. On [DATE] at 1:00 A.M., the hospital contacted the facility's nurse and informed them Resident #44 had expired. On [DATE] at 11:37 A.M., the facility's DON contacted the medical director and informed him of the occurrence and Resident #44's expiration. Review of the facility's related investigation into Resident #44's death in the facility revealed the following statements and staff interviews were obtained: A Personal Witness Statement from STNA #175 dated [DATE] for an incident date of [DATE] and time of 10:30 P.M. revealed she was standing outside (room number provided) putting on personal protective equipment (PPE) and knocked on the door and opened it. She saw Resident #44 lying in bed pale, eyes opened and fixed. She yelled for a nurse. LPN #150 came, and they pulled the resident up in bed. The nurse listened for heart sounds/ pulse. STNA #175 ran to get the resident's nurse (RN #100), who was down the hallway. LPN #150 asked what the resident's code status was. STNA #175 looked on the report sheet that she had, and it identified the resident as being a DNRCC-A. RN #100 repeated the resident was a DNRCC-A. They pulled the curtain and provided privacy. STNA #175 then indicated in her statement she left the room to answer other multiple (resident) call lights. A written interview with STNA #175 conducted by the facility's Administrator revealed the STNA was interviewed on [DATE] at 11:05 A.M. She was asked when the last time was, she had seen Resident #44 and was told by the STNA that she could not recall exactly. She had seen the resident once prior probably around 8:00 P.M. The resident reported to be okay at that time and responded appropriately. She then asked the STNA when she found the resident unresponsive and what did she do. The STNA reported she went into her room to obtain vital signs around 10:30 P.M. and the resident did not look okay. She rubbed on the resident's chest and was calling her name. The resident did not respond, so she immediately yelled for a nurse. LPN #150 came first. LPN #150 yelled for RN #100 and RN #100 came running. RN #100 checked her as well as LPN #150. RN #100 then left the room to look for the resident's code status. STNA #175 had a report sheet and showed RN #100 her report sheet, which included the resident's code status. At that point, RN #100 said the resident was a DNRCC-A and nothing further happened. The STNA was then asked what happened later. STNA #175 told the Administrator LPN #150 was at the desk and realized the resident was a full code. LPN #150 then yelled for RN #100. The STNA was asked by the Administrator if she assisted in CPR and said no, she stayed outside the room and waited for direction. A Personal Witness Statement from RN #100 dated [DATE] for an incident date of [DATE] at 10:30 P.M. revealed she arrived at the room at 10:30 P.M., after STNA #175 was yelling for help. LPN #150 was also present. A physical assessment was completed on Resident #44 and no pulse was able to be palpated. RN #100 indicated she checked the report sheet, and a DNRCC-A was reported. CPR was not initiated at that time, as the resident was thought to be a DNRCC-A. At 11:50 P.M., she spoke to LPN #150, who stated the resident's code status was confirmed as being a full code. CPR was initiated at that time and the squad was called. On [DATE] at 12:00 A.M., the squad arrived and took over the code. The resident was transported out of the facility at 12:10 A.M. to the local hospital. The hospital informed the facility staff at 1:00 A.M. that the resident was deceased . (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A written interview with RN #100 that was conducted by the facility's Administrator on [DATE] at 10:41 A.M. revealed the nurse last saw Resident #44 around 9:20 P.M. for medication administration, assessment, and personal care being performed. At approximately 10:35 P.M., STNA #175 reported the resident was found unresponsive. LPN #150 responded first and then they yelled for her (RN #100) to respond. She stated she had rushed to the room and seen the resident was unresponsive. She went to verify the code status and looked on her report sheet and the resident was listed as being a DNRCC-A. She went back to the bedside and alerted the other nurse. She did a head-to-toe assessment and verified the absence of vital signs with the other nurse as the second verifier. She went back to complete her medication pass. Later, LPN #150 offered to assist with family notification and contacting the funeral home. LPN #150 discovered that the resident was a full code in PCC. At that time, they both assisted in starting CPR. That was at 11:50 P.M. LPN #150 then instructed STNA #200 to call 911. CPR continued until the squad arrived and took over. RN #100 was asked if she had verified the resident's code status in any other way, other than by the report sheet. She denied that she had done so. She indicated the other nurse (LPN #150) tried to notify the resident's family but got no answer. She also was asked if she had notified the physician and denied that she had done so. The nurse indicated in her interview with the Administrator that was the first time she took care of the resident. The resident was alert and oriented to person, place, and time when she was assessed earlier in the night. The resident was known to be COVID-19 positive, and her assessment revealed minimal signs and symptoms of COVID-19 and notable wheezes (lung sounds) bilaterally. The resident reported she was at her normal presentation. She did have a small cough. The nurse was asked how the resident appeared when she was first found to be unresponsive. She reported the resident was in bed, she was warm by skin, pale and cyanotic. She was mottled on her bilateral lower extremities (BLE) from the knees down. A Personal Witness Statement from LPN #150 dated [DATE] for an incident date of [DATE] at 10:30 P.M. revealed she was at the end of the East Hall, when STNA #175 yelled for a nurse. She ran to (room number provided) and upon entering the room Resident #44 was pale, eyes open, and fixed. The nurse and the aide pulled the resident up in bed and the resident was unresponsive. The aide them left the room to get the resident's nurse. While remaining in the room, the nurse heard that the resident was a DNRCC. She listened for an apical pulse and checked her brachial area for a pulse. No pulses were noted. She then had RN #100 listen for an absence of an apical pulse to call the time of death. At that time, she went back to her hall to finish her medication pass. Later, she went back to ask RN #100 if there was anything she could do to help her. She got the resident's chart and there were no profile sheets or code status sheet in the hard chart. She then had to go onto the computer to find the next of kin information and the name of the funeral home. While going through her paperwork, she noticed on the back of the profile sheet that it said the resident was a full code. She spoke to the DON, and she then initiated CPR and called 911. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A written interview obtained from LPN #150 on [DATE] at 12:52 P.M. by the facility's Administrator revealed she was alerted to Resident #44's room by STNA #175 as she was yelling for a nurse, so she responded. The resident was found to be pale, eyes open and fixated, slumped forward in bed and her hand on her bed rail. The resident was noted to be mottled from her knees down and her mouth was open. She had no color in her face or lips. Her assessment revealed no respirations, no breath sounds, no pulses, no apical/ heartbeat, and her body was limp. RN #100 was the one who verified the resident's code status, and it was reported as being a DNRCC-A. She was asked what happened next and the nurse replied nothing. The resident appeared deceased without any vital signs and time of death was called. She went back to her unit and completed her medication pass. She was then asked how and who discovered the resident was a full code. She replied, after her medication pass, she went to check on RN #100 to see if there was anything she could help her with. The nurse stated she was in PCC trying to find an alternate contact because she could not reach the family listed and that was when she noticed her profile sheet said she was a full code. She called the DON to alert her of what happened and was instructed to start CPR and call 911. She yelled for RN #100 to assist and instructed STNA #200 to call 911. She immediately started compressions, and CPR was continued until the squad arrived and took over the code. She was asked what time that took place, and she indicated it was about one hour to one hour and a half after initially finding her. She denied she had verified the resident's code status prior to that, as RN #100 did. She also denied she had notified the resident's physician. A written interview conducted with STNA #200 on [DATE] at 12:12 P.M. by the facility's Administrator revealed she had no involvement and had not seen Resident #44 prior to the incident when she was found unresponsive. She was told by LPN #150 to yell for the other nurse, which she did. RN #100 came to the resident's room and came back out and was rushing around. RN #100 then stated the resident was a DNRCC-A and everything stopped. CPR was not started until around 11:45 P.M. She was instructed to call 911 and assisted with transferring the resident over to the cot. She reported the resident was very pale and limp when she assisted with her transfer. Review of the Arcadia Valley Report sheet included in the facility's investigation file revealed the sheet included the residents' names, room number, and code status. There were two report sheets in the investigative file. One report sheet was not dated but was noted to include Resident #29. The code status on the undated report sheet indicated Resident #29's code status was DNRCC-A. The second report sheet provided included a date of [DATE] and reflected Resident #29 had been moved to (room number provided). A code status (full code) for a prior resident (Resident #44) that resided in this room, before Resident #29 had been moved in, was marked out with a line and DNR was handwritten next to it. Resident #44's name had been added to the report sheet for (room number provided). The prior resident's (Resident #29) name was covered with white-out and Resident #44's name was handwritten over top of the white-out. The code status of DNRCC-A that was printed in was not marked out or covered with white-out, when Resident #29 had been moved out of the room. The row for this room and the column made for code status still reflected the resident in that room's code status was a DNRCC-A (which was identified to be inaccurate) as Resident #44's elected code status of a full code was not added as it should have been, when she was moved to that room. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 11:25 A.M., an interview with the DON and Director of Quality Assurance #250 revealed Resident #44 was moved to a different room (room number provided) after she tested positive for COVID-19 and the facility had to make some room changes. They verified staff had used white out on the report sheets to cover the name of Resident #29, who was previously in that room, and hand wrote the name of Resident #44 over top of Resident #29 name. The code status for the previous resident (Resident #29), which was a DNRCC-A, was not changed to reflect Resident #44's code status of a full code. The administrative staff revealed this was how the mix up occurred on [DATE], when Resident #44 was found unresponsive, and CPR was not initiated timely. They stated they were not able to tell who used white out to cover the prior resident's name when adding Resident #44's name on the report sheet, and after the room change had occurred. They confirmed the prior resident's (Resident #29) code status, who was in that room, was left on the report sheet instead of the code status of Resident #44 being added at the time her name was added. Review of the employee file for RN #100 revealed the nurse was suspended on [DATE] pending a nursing investigation. Her employment at the facility was then terminated on [DATE] (day after the incident). The reason for the termination included a violation of company policy, failure to follow assigned nursing protocol and job duties as assigned. The nurse's license was in good standing, and she was certified in AHA's Advanced Cardiovascular Life Support (ACLS) program at the time of the incident. On [DATE] at 1:53 P.M., an interview with Physician #500 revealed he was made aware of the occurrence with Resident #44, after the fact. He stated he was told the resident coded and was found dead. The nurses thought the resident was a DNR and had called the DON, who informed them the resident was a full code. They initiated the code then. He was not contacted when the resident was found unresponsive and was not aware of how much time had elapsed between when the resident was found deceased , when the DON was contacted, and when CPR was initiated. He stated staff would have had to initiate CPR, when it was made known Resident #44 was a full code, even though it would have been futile to attempt CPR by that time. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 3:06 P.M., a telephone interview with STNA #175 confirmed she worked on [DATE] and was assigned Resident #44's hall, when the resident was found unresponsive. She recalled working that night with RN #100, LPN #150, and STNA #200. She further confirmed that she was the STNA who found the resident unresponsive in bed at 10:30 P.M. She reported the resident did not look right when she went in the room. The resident's head of the bed was elevated, and she had one leg in bed and the other hanging over the side of the bed. She thought the resident was deceased , as she had a grayish color to her. She stated she tried to do a sternal rub on the resident, but she did not respond. She then called out for help and LPN #150 was the first one that responded. She assisted the nurse with pulling the resident up in bed and then left the room to find the other nurse. The other nurse (RN #100) was down at the end of the hall and was coming out of a resident's room, when she told her to come now. As they were responding back to the room, she was running, and the nurse was a little behind her. The nurse was asking her what Resident #44's code status was. She stated she looked at her report sheet and told the nurse the resident's code status was a DNRCC-A, as that was what was listed. The two nurses were in the room and were checking the resident for a pulse. They determined the resident was deceased at that time. The STNA stated it was chaotic. The resident was then covered up and she left the room and proceeded to go get vital signs on other residents, while the nurses proceeded to pass their medications to other residents. It was later when one of the nurses realized the resident was a full code and CPR was initiated. She was not sure how much time had elapsed between the time the resident was found unresponsive and without a pulse before they realized the resident was a full code and initiated CPR. She stated it was a while. On [DATE] at 3:18 P.M., a telephone interview with LPN #150 revealed she was one of the nurses who worked on [DATE] for the evening shift when Resident #44 was found unresponsive. She stated she knew the resident was deceased upon entering her room. She checked her for heart sounds, and they were absent. STNA #175 went to get the other nurse (RN #100). She asked what the resident's code status was and was told it was a DNRCC-A by the RN #100 and STNA #175. She told the nurse she needed to check the resident, as two nurses needed to check for a pulse when determining someone had expired. They pronounced the resident as having expired at 10:36 P.M. She reported she continued with her medication pass leaving the aide and the other nurse in the room. She stated they cleaned the resident and covered her in bed and pulled the curtain for privacy. She suspected the other nurse went on to pass her medications as well. When she finished her medication pass, she offered help to RN #100. RN #100 told her she was getting ready to reach out to Resident #44's next of kin. She assisted RN #100 in doing so. She could not find a profile sheet in the hard chart, so she obtained one from the computer. As she flipped it over to see what funeral home the resident preferred, she saw where the resident was supposed to be a full code. She called the DON and was instructed to initiate CPR and call 911. She approximated it was about an hour to an hour and a half between the time they initially pronounced the resident dead until they initiated CPR on her. She told the other nurse the resident was a full code, and they needed to initiate CPR. She started in with chest compressions while the other nurse went to get the crash cart. She was asked how a nurse would identify a resident's code status in the event the resident was found unresponsive and without a pulse or respirations. She indicated the nurse should look in the resident's electronic medical record. The LPN indicated there was COVID-19 in the facility and they had been moving resident rooms around. The other nurse and the aide looked at the report sheet when trying to determine what the resident's code status was and it erroneously said DNRCC-A. When the residents involved in the room change were moved, not all of their information on the report sheet was changed with the moves. She suspected that was how the report sheet had the incorrect code status for Resident #44. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365588	A. Building B. Wing	09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arcadia Valley Skilled Nursing and Rehabilitation	25675 East Main Street Coolville, OH 45723

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the facility undated policy on Advanced Directives revealed the facility would inform the resident about initiating an advanced directive and the facility would maintain written standards and practice guidelines regarding advanced directives to assure the resident's wishes were honored. The facility would determine the existence of advanced directives upon admission. The facility staff would document in the clinical record whether the resident had executed an advanced directive. The facility staff would provide education for staff on the healthcare facilities standards and practice guidelines on advanced directives at least annually, and they will maintain documentation of such. The physician would write an appropriate order for the resident relating to their advanced directive. All pertinent information related to advanced directives was to be documented in the resident clinical record. Review of the facility undated Emergency Care/ Code Management policy revealed the purpose of the policy was for the licensed staff of Continuing Healthcare Solutions to be prepared for resident specific emergency situations as they occur to promote the most optimal resident outcomes. Procedures included the licensed staff member would determine if the resident was unconscious. If the resident was determined not to have a palpable pulse or respirations, the licensed nurse would call for assistance, verify the resident's advanced directives/ code status in the individual resident clinical record, and if the resident was a full code, the licensed nurse would initiate CPR. The physician and the responsible party would be notified of the resident's change in condition. An order would be obtained from the physician to [NAME] [TRUNCATED]